COALITION OF WOUND CARE MANUFACTURERS

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Ms. Lisa Hines
Director, Ambulatory & Post Acute Care
Centers for Medicare and Medicaid
S3-02-01
7500 Security Blvd.
Baltimore. MD 21244

Dear Lisa:

The Coalition of Wound Care Manufacturers (CWCM), is writing to provide comments regarding the revisions of the draft MDS 3.0 document. The CWCM is comprised of the following manufacturers: ConvaTec, Smith & Nephew, Johnson & Johnson, Hartmann-Conco, Hill-Rom, KCI, CircAid and Hollister Inc. These comments are in response to your recent meeting with the National Association of Subacute and Post Acute Care (NASPAC) in Baltimore and a conversation with Peggy Dotson, Co-Chair of the CWCM who is also a member of the NASPAC.

In reviewing the draft, we commend the committee on adopting many of the recommendations provided by the NPUAP for Section M. In particular, the revisions to the descriptions for pressure ulcers and the addition of a definition and scoring for a non-stageable ulcer with necrotic tissue. This has been a problem for clinicians and it is important for them to be able to define this wound type, since a majority of these wounds are Stage IV once the necrotic tissue is removed and there are costs incurred in the removal of the necrotic tissue.

The addition of questions for arterial ulcers and diabetic foot ulcers is also positive, since these wound types were not accounted for in the previous MDS.

Unfortunately, the NPUAP recommendation to stop the process of reverse staging and to account and score for the provision of preventative skin was not adopted. These recommendations must be a priority for the next MDS adjustment, as reverse staging is contrary to good clinical practice. In addition, providing preventative measures and products such as skin barriers, incontinence barriers and pressure relieving devices are critical to reducing skin breakdown, the time to healing and overall cost to Medicare and the health care system.

For this year's MDS revision, we support the following recommendations be made to the MDS draft:

1. In Section M, to stop the practice of reverse staging, questions should be added to indicate the progression of healing that are in line with the NPUAP and WOCN guidelines for documentation, and comply with good clinical practice and documentation.

   Rationale: In the OASIS document, pressure sores are staged with definitions that indicate wound healing progress which include: not healing, early/partial granulation and fully granulating. The WOCN has issued guidelines to advise clinicians how to properly use these descriptions in the OASIS document.
   By using the same scale as in OASIS, clinicians would be able to appropriately document wound progression without reverse staging and CMS would be able to change the scoring as the wound moves to full granulation tissue, which would be equivalent to a Stage II status for payment adjustments to the RUGs.

   Clearly, the issue of reverse staging on the MDS and proper documentation on the residents' chart are in conflict and are fraught with errors and confusion. This revision would be more in line with good clinical documentation practice.

   A second issue that is problematic with reverse staging is the data concerning wounds per resident. As documented currently with reverse staging, prevalence data is skewed because the same ulcer may be documented over time as a Stage IV, III, II, then I. The MDS data collection system is a wealth of information and can be used in statistical analysis for many purposes. Since the MDS is performed on a quarterly basis determined by the admission date, residents are all on a different schedule for resubmission. If statistics are retrieved for a year, a single wound may have been coded as four different stages or wounds over the year.

2. There is an immediate need to readjust the allocation for supplies for RUGS where they are used and not spread them across all RUGS. Utilizing data from recent claims, supply allocations can be adjusted to the RUGs where supplies are most commonly utilized.

   Rationale – The current system allocates supplies evenly to all RUGS assuming providers will not need supplies for some RUGS which will offset the cost for supply use for other RUGS. This puts the provider in a loss revenue situation for any RUG where supplies are needed that exceed the allocated amount. If a provider does not admit an equivalent number of residents in RUGs who do not utilize supplies as residents who do need supplies, the provider's revenue loss could be significant. This is further complicated when a resident has both a wound (clinically complex RUG) and also classified into a high or ultra high Rehab RUG. In this case, the cost of providing care for the wound is not even included in the RUG payment calculation, severely penalizing the provider. Many providers are reluctant to accept such patients into their facility because of this negative revenue situation.

The members of the CWCM would be available at your convenience to provide further input and assistance to your group regarding these recommendations. We appreciate your openness and willingness to allow input into the MDS revision process.

Sincerely,

Marcia Nusgart R.Ph.
Executive Director